FY 1999 Prospective Payment System Payment Impact File (August 1998 Update):

This file contains data used to estimate FY 1999 payments under Medicare's prospective payment systems (PPS) for hospitals' operating and capital costs. The data are taken from various sources, including the Provider Specific File, the PPS-XI and PPS-XII cost report Minimum Data Sets, and prior years' impact files. The data set is abstracted from an internal file used for the impact analysis of the changes to PPS published in the Federal Register. This file is available for release after the PPS Proposed and Final Rules are published in the Federal Register, which generally occurs during April (Proposed) and August (Final).

FY 1999 PPS PAYMENT IMPACT FILE

File Pos.	Format	Title	Description
1-4	4.	Average Daily Census (ADC)	From cost reports
6-9	4.	Number of Beds	From cost reports
11-18	8.2	Medicare Discharges	From 1997 MEDPAR file (adjusted for transfer cases)[1,2]
20-25	6.4	Case-Mix Index	Version 16 GROUPER (adjusted for transfer cases)[3]
27-32	6.4	Operating Cost of Living Adjustment	Applied to providers in Alaska and Hawaii for operating PPS
34-39	6.4	Capital Cost of Living Adjustment	Applied to providers in Alaska and Hawaii for capital PPS
41-49	9.7	Capital Outlier Percentage	Estimated capital outlier payments as a percentage of Federal capital PPS payments
51-56	7.5	Capital Cost-to-Charge Ratio	From Provider Specific File, ratio of Medicare capital costs to Medicare covered charges
59-67	9.7	Disproportionate Share (DSH) Patient Percentage	As determined from cost report and Social Security Administration (SSA) data
69-77	9.7	Capital DSH Adjustment Factor	Applied to Federal PPS payments
79-87	9.7	Operating DSH Adjustment Factor	Applied to operating PPS payments
89-94	$6.	Hospital's Fiscal Year Ending Date	
From cost report96-103	8.2	Hospital-Specific Rate	Higher of 1982 or 1987 hospital-specific rates, updated through FY 1999. (Data for Sole Community

			Hospitals, Essential Access Community Hospitals, and Medicare-Dependent Small, Rural Hospitals.)
105-108	$4.	Pre-Reclassification Metropolitan Statistical Area (MSA)	MSA where hospital is actually located, prior to any reclassification decisions by the Medicare Geographic Classification Review Board (MGCRB). Rural areas designated by two digit SSA State codes.[4]
110-113	$4.	Post-Reclassification FY 1999 MSA (Wage Index)	MSA used for wage index assignment after reclassification by the MGCRB.
115-118	$4.	Post-Reclassification FY 1999 MSA (Standardized Payment Amount)	MSA used for standardized amount assignment after reclassification by the MGCRB.
120-126	7.5	Operating Cost-to-Charge Ratio	From Provider Specific File, ratio of Medicare operating costs to Medicare covered charges
128-136	9.7	Operating Outlier Percentage	Estimated operating outlier payments as a percentage of operating PPS payments
138-143	$6.	Provider Number	Six character provider number, first two digits identify the State[4]
145-146	2.	Provider Type	0 = Short term PPS hospital 7 = Rural Referral Center

			8 = Indian hospital 14 = Medicare-Dependent, Small Rural Hospital 16 = Sole Community Hospital 17 = Sole Community Hospital and Rural Referral Center 21 = Essential Access Community Hospital (EACH) 22 = EACH and Rural Referral Center
148-154	7.5	Resident-to-ADC ratio	Used to calculate the indirect medical education (IME) adjustment for capital PPS payments
156	$1.	Reclassification Status	Indicates hospitals reclassified by the MGCRB N = Not reclassified R = Reclassified for the standardized payment amount W = Reclassified for the wage index B = Reclassified for the standardized payment amount and the wage index L = Reclassified under Section 1886(d)(8) of the Social Security Act
158-159	2.	Census Division	Based on pre-

			reclassification MSA assignment 1 = New England 2 = Middle Atlantic 3 = South Atlantic 4 = East North Central 5 = East South Central 6 = West North Central 7 = West South Central 8 = Mountain 9 = Pacific 40 = Puerto Rico
161-166	6.4	Resident-to-Bed Ratio	Used to determine IME factor for operating PPS payments
168-176	9.7	Capital IME Adjustment	Based on resident-to-ADC ratio
178-186	9.7	Operating IME Adjustment	Based on resident-to-bed ratio
188-193	$6.	Pre-Reclassification Urban/Rural Location	Urban/rural designations based on geographic location prior to reclassification by the MGCRB LURBAN = Large urban area OURBAN = Other urban area RURAL = Rural area
195-200	$6.	Post-Reclassification Urban/Rural Location	Urban/rural designations after reclassification by the MGCRB (see pre-reclass urban/rural location for

			key)
202-207	6.4	Medicare Utilization Rate	
Medicare days as a percentage of total inpatient days. (Data not available for all hospitals)209-217	9.7	Capital Wage Index	Used to determine geographic adjustment factor
219-227	9.7	Operating Wage Index	Applied to labor-share of standardized amount
229-232	4.	Mileage to Nearest Hospital	Travel distance, used to determine eligibility for hospital-specific payments for reclassified sole community hospitals.
239-247	9.7	Puerto Rico Capital Wage Index	Used to adjust the Puerto Rico capital rate.
249-257	9.7	Puerto Rico Operating Wage Index	Used to adjust the labor portion of the Puerto Rico operating standardized amount.

Notes:

[1] Medicare discharges are adjusted to account for the less-than-full (per diem) payment hospitals receive for cases transferred to another PPS hospital prior to reaching the geometric mean length of stay for the DRG. The adjustment is calculated by accounting for transfers in proportion to the total per diem payment relative to the full DRG amount, calculated as:

1 X (Length of stay prior to transfer plus one day ÷ Geometric Mean LOS),

where the result cannot exceed 1.

[2] In addition to transfers from one PPS hospital to another, Medicare discharges are adjusted to account for the implementation of section 4407 of the Balanced Budget Act, which requires Medicare to pay as transfers

discharges from 10 DRGs to postacute care. In the case of seven of these DRGs (14, 113, 236, 263, 264, 429, and 483), transfers to postacute care are paid using the same methodology as transfers from one PPS hospital to another. For three DRGs (209, 210, and 211), payment is equal to half of what the case would get under the PPS to PPS transfer methodology, and half of what the case would be paid if it were paid as a normal discharge.

[3] The case-mix index is also adjusted to account for transfers occurring before the geometric mean length of stay. This adjustment is calculated as:

$$\frac{\text{Sum of (DRG Relative Weight X (Transfer Payment Amount} \div \text{Full DRG Payment Amount))}}{\text{Transfer adjusted number of Medicare discharges.}}$$

[4] SSA State Codes:

01	ALABAMA
02	ALASKA
03	ARIZONA
04	ARKANSAS
05	CALIFORNIA
06	COLORADO
07	CONNECTICUT
08	DELAWARE
09	DISTRICT OF COLUMBIA
10	FLORIDA
11	GEORGIA
12	HAWAII
13	IDAHO
14	ILLINOIS
15	INDIANA
16	IOWA
17	KANSAS
18	KENTUCKY
19	LOUISIANA
20	MAINE
21	MARYLAND
22	MASSACHUSETTS
23	MICHIGAN
24	MINNESOTA
25	MISSISSIPPI
26	MISSOURI
27	MONTANA
28	NEBRASKA
29	NEVADA
30	NEW HAMPSHIRE
31	NEW JERSEY
32	NEW MEXICO
33	NEW YORK
34	NORTH CAROLINA
35	NORTH DAKOTA
36	OHIO
37	OKLAHOMA
38	OREGON
39	PENNSYLVANIA

40 PUERTO RICO
41 RHODE ISLAND
42 SOUTH CAROLINA
43 SOUTH DAKOTA
44 TENNESSEE
45 TEXAS
46 UTAH
47 VERMONT
49 VIRGINIA
50 WASHINGTON
51 WEST VIRGINIA
52 WISCONSIN
53 WYOMING
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